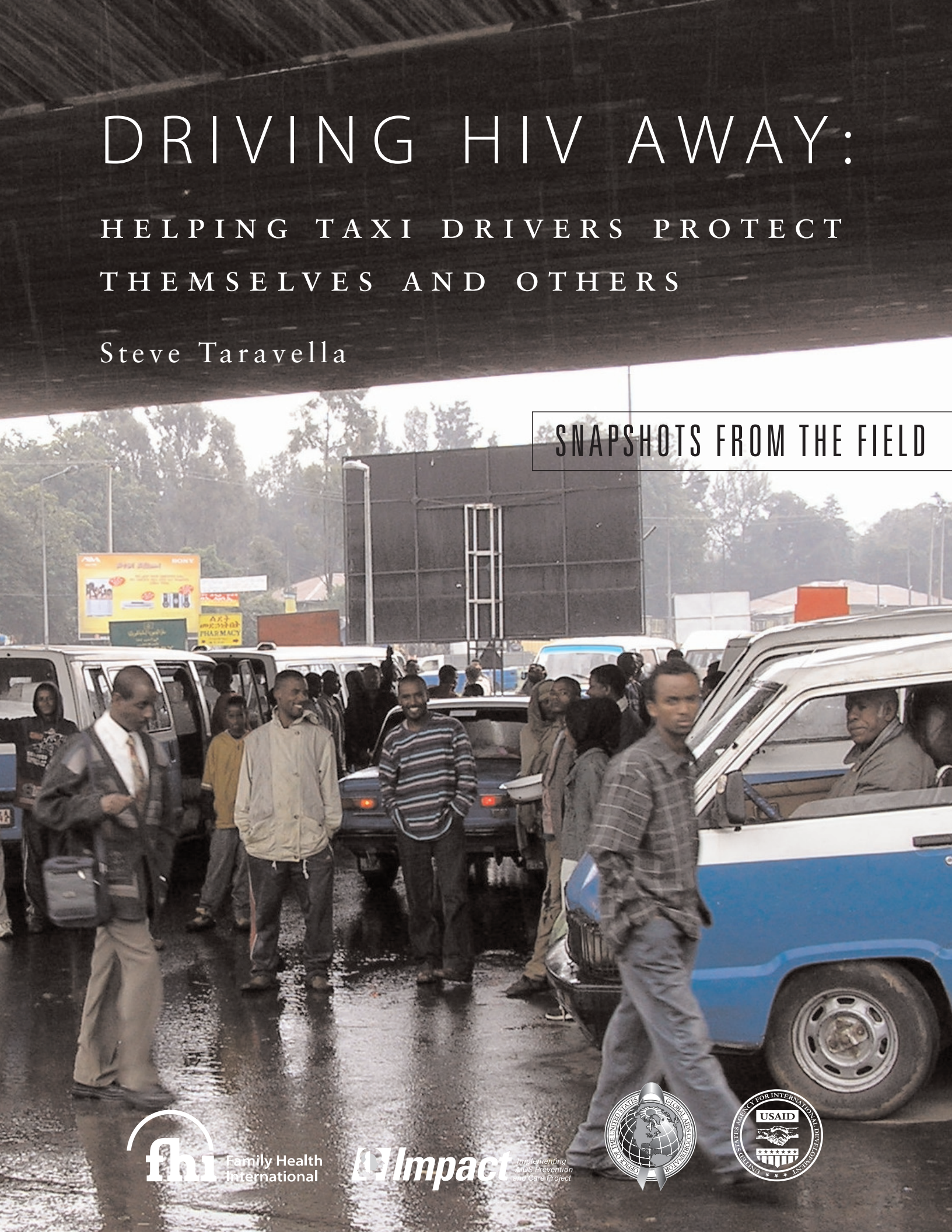
DRIVING HIV AWAY:

HELPING TAXI DRIVERS PROTECT THEMSELVES AND OTHERS

Steve Taravella

SNAPSHOTS FROM THE FIELD



Family Health International
Impact Implementing AIDS Prevention and Care Project
USAID

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Cover photo: At gathering places like this central Addis Ababa taxi station, FHI/IMPACT and SYGA are educating taxi drivers, assistants and inspectors to protect themselves and their families from HIV.

Semere is a handsome, 24-year-old Ethiopian. He has a girlfriend but occasionally has sex with other women. He says he mostly uses condoms, but does not want to be seen buying them. He has chosen not to learn his HIV status.

He is also a taxi driver in Addis Ababa, which makes him a prime audience for a new program introduced by the Implementing AIDS Prevention and Care Project (IMPACT), which is managed by Family Health International (FHI). Working with local partner Save Your Generation-Ethiopia (SYGA) and the Addis Ababa HIV/AIDS Prevention and Control Office, IMPACT aims to bring messages of HIV prevention and behavior change to the 28,000 men who work as taxi drivers , taxi assistants or taxi inspectors in the city. Their blue-and-white mini-buses, a familiar site on the streets of Addis Ababa, are a major form of transportation in this city of about five million.

Most taxi drivers are young, unmarried men who have received little education and little information about HIV. They are further vulnerable to infection because they travel throughout the city during their work, encounter many different people, receive money—and sometimes find themselves pursued by women who hope the drivers will spend money on them.

The primary goal of the program, which is funded by the Office of the Global AIDS Coordinator through the U.S. Agency for International Development (USAID), is to educate drivers about HIV so they can better protect themselves and their families. “There must be a behavior change in this community. People are dying,” says Mekte Game, a taxi inspector. The behavior change is approached through peer education, augmented by drama presentations at taxi stations where drivers gather and by condom distribution. The condoms are provided by DKT-Ethiopia, the Addis Ababa Health Bureau and local HIV/AIDS Prevention and Control Desks.

A secondary goal of the program is to help drivers like Semere become more comfortable discussing HIV with passengers; in this regard, drivers can function as community educators, transforming a passenger experience into an opportunity to improve community health.

Evidence suggests a great need for targeting taxi drivers with such activities. For a 2003 formative assessment on behavior change communication, FHI and the Addis Ababa HIV/AIDS Secretariat conducted focus groups with male taxi drivers ages 21 to 30 in Merkato, Addis Ketema (Awtobus Terra) and Arada. Though most were single, “none of the taxi drivers felt that they were at risk for HIV infection,” the assessment found. Yet they generally were afraid of dying from AIDS. “I do not even like to say its name,” one taxi driver said. Another driver likened HIV infection to “living in the darkness.”

“All of them considered that contracting HIV was a point of no return in life,” the assessment found. Some felt HIV-positive persons should be isolated from others. Some believed HIV was present in the lubricant on condoms. A few believed condoms were “an instrument for white

people to eliminate black people." Some taxi drivers were dissuaded from using condoms by the local attitude that those who buy or carry condoms are promiscuous.

Semere, a former mechanic who has been driving taxis for five years, recently talked to a visitor about HIV in the taxi community. Sitting in his vehicle, parked in a crowded taxi station on a rainy afternoon, Semere spoke in Amharic about his life as a taxi driver and the ways in which his livelihood affects his sexual health.

As a permanent, salaried driver, he earns 300 birr (about US$40) per month from the owner of the mini-bus he drives. Semere and his assistant, whose primary job is to collect fares, each take home an additional 20 birr daily from fares (about US$2.25). For this money, Semere starts his day at 6 a.m. and works until 9 p.m., with only one day off work each month. His aging vehicle, with its dusty interior and well-worn seats, can accommodate 11 passengers and a driver.

Because his is a good income in Addis Ababa, Semere is often approached by young women and frequently has sex with them. Though most taxi drivers are "careless," not using condoms, he says he does use condoms. He knows where to buy them, at 25 cents for three, but so great is the stigma associated with sexual activity that he does not want to be seen purchasing them. In this close-knit community, he fears the shop-keeper will tell Semere's family or neighbors that he is having sex with many women, possibly even sex workers. So Semere sends young boys, and sometimes his younger assistant driver, to buy them for him.

Because he does not want to become seriously involved with these young women, if one should return to see him a second time, as sometimes happens, he might "deliver her" to another driver for sexual activity, or simply drop her at a hotel—but not before using his cell phone to alert a fellow driver of her location and availability for sex.

The drivers are also vulnerable because many of them use *khat*, a stimulant they chew in the afternoons. When mixed with alcohol, *khat* increases their vulnerability, outreach workers say.

Semere, who stopped using *khat* three years ago, believes he has escaped HIV infection. He is concerned about HIV, but not because of his casual sexual encounters. He is concerned he may contract HIV from his regular girlfriend, whose photo he proudly pulls from his wallet. She is living for a month in a nearby Arab country, where she has found work. He fears she may have sex with other men while there.

Addis Ababa's taxi drivers and assistants—virtually all of whom are men—are more likely to consider information from their fellow drivers than from public health educators; Semere says he is most likely to respond to HIV information if he receives it from other drivers because they also make up his social network. Based upon this understanding, FHI/MPACT and SYGA have so far prepared 20 of the city's taxi inspectors to become core trainers. The inspectors, who function as

dispatchers and schedule coordinators but who also drive vehicles, train a small number of drivers to be peer leaders. These 20 men, in turn, have trained 100 peer leadership trainers, who have now trained 553 peer leaders to work with their peers and, ultimately, to educate the city's fleet of drivers.

The program helps taxi drivers become comfortable discussing HIV with their passengers.

None are paid for this work, and turning taxi drivers into educators is not easy. "No driver enjoys such chat [about HIV/AIDS]. Rather, they prefer to talk about Manchester United and Arsenal football clubs in England," one focus group participant said. Another said, "We talk about the traffic charge, not about such sexual issues." Semere says he and his driver buddies do talk about their sexual activity, but just the who and where—rarely what and never anything about the specter of HIV.

But focus group participants said advertisements posted on their vehicles, radio messages broadcast in their vehicles, and pamphlets placed at taxi stations are effective ways to improve taxi drivers' HIV knowledge.

As is street theatre.

At large taxi stations, drivers stop their work and climb atop the roofs of their vehicles to watch the mobile dramas, produced by SYGA Performed by volunteers, the dramas are participatory, allowing the taxi drivers to help determine how stories end. Semere says a recent skit "reinforced that I should keep myself safe and have safe sexual behavior. At the top of the list, even though I have casual sex and I have condoms, is to be faithful to my partner."

A recent interview with three core trainers reveals these efforts—peer training, condom education and street theatre—are making important inroads. "Before the training, we never discussed HIV with colleagues. Now, people come to me with all sorts of questions on HIV/AIDS, and they use the information," says taxi inspector Samuel Birhane.

Access to credible information is so valued that even before inspector Nega Zafu had completed his training, other drivers were approaching him with questions. One, for instance, sought advice about symptoms he suspected might indicate a sexually transmitted disease. When Nega finished his training, he cautiously brought up condoms with a fellow driver. Doing so opened up a conversation about proper condom use, expiration dates and other helpful details, he says.

Similar changes have occurred with passenger interaction, too. If Samuel sees a billboard or sign about HIV, or hears a radio spot about AIDS, he might seize it as an opportunity to initiate a discussion. Moreover, if he overhears a conversation among passengers about AIDS, he now might offer a comment about condoms. Drivers would never have facilitated discussion about HIV before this program, he said.

Partly that is because of widespread HIV denial and stigma, strong obstacles IMPACT and SYGA must address. Semere, for instance, at first claims to know no one with AIDS, but when pressed, acknowledges that when his own brother died two years ago, the family did not know the exact cause.

"If a taxi driver is found to be HIV-positive, he will be rejected by the society," one said. Focus group participants described the discrimination itself as "another AIDS."

One ramification of this stigma is a reluctance to seek HIV testing and counseling services. FHI, with USAID funding, supports 25 public-sector testing and counseling sites that have served more than 40,000 people throughout Addis Ababa in the past year. The sites use rapid testing technology. Some charge 10 birr for a test, but provide it free to those who cannot pay. Most focus group participants did not know counseling and testing services exist. Some drivers who were aware of such services resisted them, saying VCT would not be practical unless the testing was compulsory. Some had been required to take an HIV test by a job or visa application. One participant said, "I will only visit VCT if I get a chance to go to America."

Tim is another obstacle to testing. Semere must work each day, so leaving work for any reason is difficult. An hour spent at a counseling and testing service is an hour without income. To address this difficulty, the Addis Ababa Health Bureau now keeps some public-sector VCT services open later in the evenings and on Saturdays. Yet even Semere appreciates the irony in his life: He has not been tested, but his mini-bus sports a bumper sticker that promotes VCT.